New Jersey Department of Children and Families Policy Manual

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PURPOSE AND USE

The summary provides the guidelines used at the FXB Center for children at UMDNJ-Newark for screening infants and children that are at risk for HIV infection.

HIV Screening of Infants and Children at Risk for HIV Infection

The following is a summary of the guidelines used at the FXB Center for children at UMDNJ-Newark. They are based on a combination of 1) clinical experience, 2) peer reviewed literature, 3) the CDC endorsed 1995 Revised Guidelines for the Prophylaxis Against Pneumocystis carinii Pneumonia for Children Infected with Human Immunodeficiency Virus (see attached table), 4) the 1994 Revised CDC Classification System for HIV Infection in Children less than 13 years of age and, 5) the CDC Recommendations for the Use of Antiretroviral Agents in Pediatric HIV Infection, April 1998. Please note that these are guidelines that reflect only the minimum amount of laboratory testing to be performed on a patient. These guidelines are meant to be expanded if warranted by the clinical situation.

Laboratory Evaluation and PCP Prophylaxis for Infants Born to Women with HIV Infection*:

Laboratory tests are listed in order of importance for each age group.

Initial Visit:

I. Age: Birth to two weeks:
   1.) HIV Qualitative DNA PCR should be performed before the infant is 48 hours old.
   2.) If an HIV DNA PCR was not obtained before 48 hours of age, one should performed as soon as possible after that time.
   3.) No other HIV specific laboratory evaluation is necessary at this time.
   4.) The initial visit should include a full history and physical examination as well as a discussion of the expected visit schedule and laboratory

evaluation involved in testing infants for HIV infection. Pretest counseling should be performed at this time and informed consent for HIV testing be obtained.

[*An infant born to a woman whose HIV status is unknown who is seen for the first time at less than two weeks of age should have an HIV serology performed at that time. An infant born to a woman whose HIV status is unknown but is considered at high risk for HIV infection, who is evaluated for the first time at less than two weeks of age, should be evaluated in the same manner as an infant born to a woman with known HIV infection. Every attempt should be made to determine the HIV status of the mother in this case. Every child should have an HIV serology performed at the first visit.]

II.) Age: Two weeks to 12 months:
Laboratory evaluation:
1.) HIV DNA PCR
2.) CD_4 count and percentage
3.) CBC with differential
4.) HIV serology

A full history including prior maternal use of antiretroviral therapy to interrupt transmission of HIV infection should be obtained. A physical examination should be performed along with a discussion of the purpose of the testing and full pretest counseling. Informed consent for HIV testing must be obtained.

Intervention: Begin PCP Prophylaxis at 4-6 weeks of age (6 weeks for infants on zidovudine).

III. Age: 12 to 18 months:
If HIV seropositive by history or documentation:
1.) CD_4 count and percentage
2.) HIV serology

If HIV status of mother unknown or if child never tested*:
1.) HIV serology

[If child has a clinical history suggestive of HIV infection, obtain CD_4 count and percentage at this visit.]

IV. Age: Greater than 18 months:
If HIV seropositive and documentation is available indicating the serology was obtained after 18 months of age:
1.) Repeat the serology to confirm the initial positive test
2.) CD_4 count and percentage
3.) Refer to case management

If HIV status is unknown (child never tested or documentation lacking)

1.) HIV serology

Follow up visits for patients one to 12 months of age are given as follows:

1.) All follow up visits for results are given for two weeks.
2.) If positive results are received, every effort will be made to reschedule this appointment for an earlier date.
3.) All children on PCP prophylaxis must be seen for a CBC with differential and platelet count every 4-6 weeks.

Second Visit:

1.) Age 2 weeks to 4 months:
Laboratory evaluation:
1.) HIV DNA PCR
2.) CBC with differential and platelet count

At this visit any previously obtained laboratory results should be reviewed and the continued use of PCP prophylaxis should be encouraged. An interim history will be performed and a physical examination will be performed based on the interim history if needed.

If the initial HIV DNA PCR is reactive, a presumptive diagnosis of HIV infection can be made. The patient should be transferred to a care team unless clinical evaluation leads the clinician to feel that there is the possibility that the result is a false positive. All children with a reactive HIV DNA PCR should have a DNA PCR and an HIV DNA PCR performed as soon as possible.

2.) Age 4 months to 12 months:
Laboratory evaluation:
1.) HIV DNA PCR
2.) CBC with differential and platelet count

At this visit any previously obtained laboratory results should be reviewed and the continued use of PCP prophylaxis should be encouraged. An interim history will be performed and a physical examination will be performed based on the interim history if needed.

If the initial HIV DNA PCR is reactive, a presumptive diagnosis of HIV infection can be made. The patient should be transferred to a care team unless clinical evaluation leads the clinician to feel that there is the possibility that the result is a false positive. All children with a reactive HIV DNA PCR should have a DNA PCR and an HIV DNA PCR performed as soon as possible.

3.) Age greater than 12 months:

If HIV seropositive:

1.) HIV DNA PCR (if child is less than 16 months old)
2.) CD_4 count and percentage (if not done at first visit)
3.) Schedule follow-up visit for two weeks to decide on need for PCP prophylaxis

If HIV seronegative:

1.) Repeat HIV serology

Subsequent Evaluation:

Subsequent evaluations will depend upon the specific clinical situations and the need for specific diagnostic and immunologic monitoring taking into consideration the following:

1.) A presumptive diagnosis of HIV infection is made with a single reactive HIV DNA or RNA PCR . Upon obtaining a single reactive viral diagnostic assay result, the test is repeated and the child is referred for subspecialty care.

2.) A diagnosis of HIV infection can be made with a positive serology in a child older than 18 months of age. Positive serology in this age group should be repeated as soon as possible for confirmation of the diagnosis. It is useful for staging purposes to obtain an HIV RNA PCR and a CD_4+ lymphocyte count.

3.) HIV infection can be reasonably ruled out with two negative HIV DNA PCR tests, the first being obtained at $\geq$ 1 month of age and the second being obtained at $\geq$ 4 months of age.

4.) Two negative HIV serology results are required at $\geq$ 12 months of age with one being $\geq$ 18 months of age prior to discharge from screening clinic.

5.) CD_4 counts and percentages should be obtained on infants at one and three months of age.

6.) Children on PCP prophylaxis should have a CBC with differential and platelet count every 4-6 weeks.

PCP prophylaxis should be continued on all infants throughout the first year unless HIV infection has been reasonably ruled out on the basis of two negative viral diagnostic assays. Children who are diagnosed with HIV infection should continue on PCP prophylaxis through the end of the first year of life. At one year of age, a decision should be made as to whether or not to continue PCP prophylaxis based on the Revised 1995 PCP Prophylaxis Guidelines.

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FXB Center for Children